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# 18 Hospice

Hospice is an interdisciplinary program of palliative care and supportive services that address the physical, spiritual, social and economic needs of terminally ill patients and their families. This care may be provided in the patient's home or in a nursing facility, if that is the recipient's place of residence.

The Alabama Medicaid Hospice Care Services Program began October 1, 1990, in order to help people who meet the criteria for hospice services remain in their homes.

Medicaid offers hospice care services to Medicaid-eligible recipients who are terminally ill as certified by the medical director of the hospice, or by the physician member of the hospice inter-disciplinary group and the individual's attending physician, if present. An individual is considered to be terminally ill if the medical prognosis indicates a life expectancy of six months or less. Hospice care consists of services necessary to relieve or reduce symptoms of the terminal illness and related conditions.

Medicaid hospice care services are subject to Medicare special election periods applicable to hospice care. Medicaid uses the most recent benefit periods established by the Medicare Program.

Effective June 16, 2005, all Hospice Providers are required to use criteria specific to the Medicaid program to determine medical necessity for recipients electing the hospice benefit when Medicaid is the primary payor. Providers should no longer use the Palmetto GBA Medicare Local Medical Review Policy (LMRP) to determine medical necessity for the hospice program when Medicaid is the primary payor for the hospice services. Providers should continue to use the Palmetto GBA LMRP for dually eligible recipients with Medicare Part A who reside in the community or a nursing facility because Medicare is considered the primary payor for these individuals. The Medicaid hospice criteria should be used to establish eligibility for the following categories of hospice recipients:

- All recipients with full Medicaid benefits
- All recipients with Medicaid and Medicare Part B
- All recipients who are Qualified Medicare Beneficiaries (QMBs) with full Medicaid coverage.

The policy provisions for Hospice providers can be found in Chapter 51 of the *Alabama Medicaid Agency Administrative Code,* and on the agency website at www.medicaid.alabama.gov. For diagnoses not found in the Alabama Medicaid Agency administrative code or for pediatric cases medical necessity review will be conducted on a case-by-case basis.

## 18.1 Enrollment

EDS enrolls hospice providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

**Provider Number, Type, and Specialty**

A provider who contracts with Medicaid as a hospice provider is issued an eight-character Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for hospice-related claims.

| **NOTE:** |
| --- |
| All eight characters are required when filing a claim. |

Hospice providers are assigned a provider type of 47 (Hospice). Valid specialties for hospice providers include Hospice (H6).

**Enrollment Policy for Hospice Providers**

To participate in Medicaid, hospice providers must meet the following requirements:

Receive certification from the Centers for Medicare and Medicaid Services that the hospice meets the conditions to participate in the Medicare program.

- Possess a letter from the state licensing unit showing the permit number and effective date of the permit
- Possess a document from the licensing unit showing that the hospice meets requirements for the Medicare program
- Possess a copy of the notification to the hospice showing the approved Medicare reimbursement rate, the fiscal year end, and the Medicare provider number

Only hospice programs physically located within Alabama or within 30 miles of the state line may participate.

## 18.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Hospice providers must establish and maintain a written plan of care for each individual admitted to a hospice program. All services provided by the hospice must adhere to the plan.

The hospice must submit required hospice election and physician certification documentation to Medicaid for coverage of hospice care.

### 18.2.1 Physician Certification

The hospice must obtain physician certification that the individual recipient is terminally ill.

For the first period, the hospice must obtain written certification statements signed by the medical director of the hospice or the physician member of the interdisciplinary team and the recipient's attending physician, if present. The hospice must obtain physician certification no later than two calendar days after hospice care begins.

If the hospice does not obtain written certification as described, the hospice may obtain verbal certification within the two-day period, but must obtain written certification no later than eight calendar days after care begins. If every effort is made to secure written certification within eight calendar days and the hospice provider has not obtained the written certification, then a physician signature obtained by fax will meet the certification requirement. Written certification must be secured and retained in the client record within 30 days of the hospice election.

For each subsequent period, the hospice must obtain a written certification prepared by the medical director of the hospice or the physician member of the interdisciplinary team. The hospice must obtain physician certification no later than two calendar days after the period begins.

Each written certification must indicate that the recipient's medical prognosis is such that his or her life expectancy is six months or less. The hospice must retain these certification statements.

### 18.2.2 Election Procedures

In order to receive hospice care benefits, an individual must qualify for Medicaid and be certified as terminally ill by a doctor of medicine or osteopathy.

An election period is a predetermined timeframe for which an individual may elect to receive medical coverage of hospice care. Individuals may receive hospice care for two 90-day election periods, followed by an unlimited number of subsequent periods of 60 days each.

An individual eligible for hospice care must file an election certification statement with a particular hospice. Beginning April 1, 2005, all Hospice providers must complete the Medicaid Hospice Election and Physician's Certification Form 165 to certify Medicaid recipients for the hospice program. The Medicaid Agency will recognize the Medicare election form as election for both Medicare and Medicaid for dually eligible recipients receiving hospice services in the community. When a dually eligible recipient enters the nursing facility the Hospice Recipient Status Change Form 165B must be completed and returned to the Long Term Care Admissions/Records Unit. Hospice providers must also use this form to report subsequent changes for all hospice recipients during the hospice certification period. Due to the terminally ill individual's mental or physical incapacity, a representative may be authorized to file an election.

An election to receive hospice care is considered to continue from the initial election period through the subsequent election periods without a break in care as long as the following criteria are met:

- Recipient remains in the care of a hospice

- Recipient does not revoke the election provisions
- Election is re-certified when there is a break in care

An individual or representative may designate an effective date that begins with the first day of hospice care or any subsequent day of hospice care. The two 90-day election periods must be used before the 60-day periods. An individual or representative may not designate an effective date earlier than the date that hospice care begins.

A Medicaid beneficiary who resides in a nursing facility may elect to receive hospice services. The hospice must have a contract with the nursing facility that clearly states which services each has responsibility to provide and details how the nursing facility and hospice will work together.

### *18.2.3 Medical Records*

The hospice has the responsibility to establish and maintain a permanent medical record for each patient that includes the following:

Physician certifications

Services provided

Recipient election statement(s)

Interdisciplinary treatment plan of care and updates

Advance directive documentation

The documentation contained in the medical record must be a chronological, complete record of the care provided to the hospice recipient. The medical record must contain the Medicaid Hospice Election and Physician's Certification, Form 165 that is signed and dated by the physician. A Form 165 must be present for each election period. The documentation must contain the physicians' orders that include medication(s) taken by the recipient, an assessment and a plan of care developed prior to providing care by the attending physician, the medical director or physician designee, and the interdisciplinary team. Identification of a specific terminal illness must be documented and substantiated by labs, x-rays and other medical documentation supporting the terminal illness as set forth by the Medicare/Medicaid guidelines.

The hospice retains medical records for at least three years after the current year.

### *18.2.4 Advance Directives*

The hospice must document in the patient medical records that each adult recipient has received written information regarding rights to make decisions about his or her medical care, under state law.

The hospice must comply with requirements in the Medicaid contract concerning advance directives.

### *18.2.5 Waiver of Other Benefits*

An individual receiving hospice care waives all rights to Medicaid services covered under Medicaid for the duration of hospice care. Waived services include the following:

- Hospice care provided by any hospice other than the hospice designated by the recipient, unless provided under arrangements made by the designated hospice
- Any Medicaid services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition
- Any Medicaid services that are equivalent to hospice care

Individuals receiving hospice care **do not waive** the following benefits:

- Services provided by the designated hospice
- Services provided by another hospice under arrangements made by the designated hospice
- Services provided by the individual's attending physician if that physician is not an employee of and does not receive compensation from the designated hospice for those services
- Medicaid-covered services that are not related to the hospice recipient's terminal illness

### *18.2.6 Election Revocation*

An individual or representative may revoke the individual's election of hospice care at any time during an election period. If an individual revokes the election to receive hospice care, any days remaining in that election period are forfeited.

The hospice sends the Alabama Medicaid Hospice Care Program the **Hospice Recipient Status Change Form 165B** to revoke the individual's election for Medicaid coverage of hospice care.

Upon revocation of the election of Medicaid coverage of hospice care, an otherwise Medicaid eligible recipient resumes Medicaid coverage of the benefits waived when hospice care was elected.

| **NOTE:** |
| --- |
| An individual should not revoke the hospice benefit when admitted to the hospital for a condition related to the terminal illness. |

### *18.2.7 Change of Hospice*

An individual or representative may change the designation of the particular hospice that provides hospice care one time per election period. The change of the designated hospice is not a revocation of the election for the period in which it is made.

To change the designated hospice provider, the individual or representative must file a signed statement that includes the following information:

- The name of the hospice from which care has been received
- The name of the hospice from which the individual plans to receive care
- The effective date of the hospice change
- The hospice provider transferring the recipient should submit a Hospice Recipient Status Change Form 165B indicating transfer of the recipient

- The accepting hospice provider should submit documentation to the LTC Admissions Records Unit for review and processing to the LTC file

The individual or representative must provide a copy of this statement to the hospice provider and to Medicaid.

The waiver of other benefits remains in effect.

### *18.2.8 Covered Services*

Nursing care, physician services, medical social services, and counseling are core hospice services routinely provided directly by hospice employees.

Appropriately qualified personnel as determined by the nature of the service must perform all covered services.

The following are covered hospice services:

| ***Covered Services*** | ***Description*** |
|---|---|
| Nursing facility care | Provided by or under the supervision of a registered nurse |
| Medical social services | Provided by a social worker who has at least a bachelor's degree from an approved or accredited school and who works under the direction of a physician |
| Physician services | Performed by a licensed physician. The medical director and physician member of the interdisciplinary group must be a doctor of medicine or osteopathy. |
| Counseling services | Provided to the terminally ill individual and the family or other person(s) caring for the patient at home. Counseling includes dietary advice, caregiver training, and counseling for adjustment to approaching death for patients and caregivers. |
| Short-term inpatient care | Provided in a participating hospice inpatient unit or a hospital or nursing facility that provides services through a contract with the hospice. General inpatient procedures necessary for pain control or acute or chronic symptom management that cannot be provided in another setting; respite inpatient care lasting up to five consecutive days may provide relief for the individual's caregiver at home. Medicaid will not cover respite care when the recipient is a nursing facility resident. These inpatient services must be part of the written plan of care. |
| Medical appliances and supplies | Includes drugs and biologicals provided to the patient. Drugs must be used primarily for relief of pain and symptom control related to the individual's terminal illness and related conditions. Appliances include durable medical equipment as well as other self-help and personal comfort items provided by the hospice for use in the patient's home for the palliation or management of the patient's terminal illness and/or related condition. These appliances and supplies must be included in the written plan of care. |
| Home health aide services | Furnished by qualified aides and homemaker services provided under the general supervision of a registered nurse. These services include personal care and maintenance of a safe and healthy environment as outlined in the plan of care. |
| Physical Therapy, Occupational Therapy, and Speech Language Therapy | Provided for symptom control or to allow the recipient to maintain basic functional skills and/or activities of daily living |

Hospices may contract for supplemental services during periods of peak patient loads and to obtain physician specialty services.

## *18.2.9 Reimbursement for Levels of Care*

With the exception of payment for direct patient care services by physicians, Medicaid pays the hospice for all covered services related to the treatment of the recipient's terminal illness for each day the recipient is Medicaid-eligible and under the care of the hospice, regardless of the services furnished on any given day.

Payment for hospice care must conform to the methodology and amounts calculated by the Centers for Medicare and Medicaid Services (CMS). Medicaid bases hospice payment rates on the same methodology used to set Medicare rates and adjusts rates to disregard offsets due to Medicare co-insurance amounts. Each rate comes from a CMS estimate of the costs generally incurred by a hospice in efficiently providing hospice care services to Medicaid beneficiaries. Medicaid adjusts the rates of reimbursement to reflect local differences in wages.

Medicaid pays reimbursements to the dispensing pharmacy for drugs not related to the recipient's terminal illness through the Medicaid Pharmacy Program.

Added: NOTE

**NOTE:**

Reimbursement for disease specific drugs related to the recipient's terminal illness as well as drugs found on the Hospice Palliative Drug List (HPDL) are included in the per diem for hospice covered services and will not be reimbursed through the Medicaid Pharmacy Program. The HPDL is on the agency website at www.medicaid.alabama.gov.

With the exception of payment for physician services, Medicaid reimburses hospice care at one of four rates for each day in which a Medicaid recipient receives hospice care. The payment amounts are determined within each of the following categories:

- Routine home care
- Continuous home care
- Inpatient respite care
- General inpatient care

**Routine Home Care**

The hospice receives reimbursement for routine home care for each day that the recipient receives hospice care at home but does not receive continuous home care. Medicaid pays this rate without regard to the volume or intensity of routine home care services provided on any given day.

**Continuous Home Care**

The hospice receives reimbursement for continuous home care when the recipient receives nonstop nursing care at home. Continuous home care is intended only for periods of crisis when skilled nursing care is needed on a continuous basis to manage the recipient's acute medical symptoms, and only as necessary to maintain the recipient at home. Continuous home care consists of a minimum of eight hours per day.

### Inpatient Respite Care

The hospice receives reimbursement for inpatient respite care for each day that the recipient receives respite care. Patients admitted for this type of care do not need general inpatient care. Medicaid provides inpatient respite care only on an intermittent, non-routine, and occasional basis and will not reimburse for more than five consecutive days, including date of admission, but not date of discharge.

### General Inpatient Care

The hospice receives reimbursement for general inpatient care for each day that the recipient occupies an approved inpatient facility for the purpose of pain control or acute or chronic symptom management.

**NOTE:**

Payment for total inpatient care days (general or respite) for Medicaid patients cannot exceed twenty percent of the combined total number of days of hospice care provided to all Medicaid recipients during each 12-month period of November 1 through October 31.

### Reimbursement for Physician Services

The basic payment rates for hospice care are designed to reimburse the hospice for the costs of all covered services related to the treatment of the beneficiary's terminal illness, including the administrative and general supervisory activities performed by physicians employed by or working under arrangements made with the hospice.

Group activities, which include participation in establishing plans of care, supervising care and services, periodically reviewing and updating plans of care, and establishing governing policies are included in the reimbursement rates for routine home care, continuous home care, and inpatient respite care. Direct patient care services by physicians are reimbursed as follows:

- Physicians employed by or working under arrangements made with the hospice may bill for direct patient care services rendered.
- Services provided by the attending physician who is not employed by or receiving compensation from the hospice will be paid to that physician in accordance with the usual billing procedures for physicians. Refer to Chapter 28, Physician, for physician billing procedures.
- Services furnished voluntarily by physicians where the hospice has no payment liability are not reimbursable.

### Nursing Facility Residents

Medicaid will not restrict hospice services based on a patient's place of residence. A nursing facility resident may elect to receive hospice benefits if he or she meets the requirements for hospice care under the Medicaid program.

If the resident elects to receive hospice benefits, the nursing facility submits discharge information per LTC Admission Notification Software.

A Medicaid hospice recipient residing at home who enters a nursing facility may continue to receive services under the hospice benefit. Any applicable resource liability amount and/or third party liability amount for a nursing facility resident need to be established and applied to the amount paid to the hospice

by Medicaid for the nursing facility services. Nursing facility residents are required to use income to offset the cost of nursing facility care. Additionally, if a resident in a nursing facility elects, the hospice income will be applied to offset the cost of hospice care. The Medicaid district office will provide the hospice provider a copy of the Notice of Award or Notice of Change of Liability in order to inform the hospice of the claimant's liability required amount to be paid from claimant's income.

The Nursing Facility should use the Hospice Recipient Status Change Form 165B to report the following information to the Long Term Care Admissions/Records Unit for **dually eligible** institutionalized recipients:

- Initial nursing home admission
- Discharge from the nursing home to the hospital
- Discharge from the nursing home to the community
- Expiration in the nursing home
- Readmission to the nursing home from the hospital

The Nursing Facility should use the Hospice Recipient Status Change Form 165B to report the following information to the Long Term Care Admissions/Records Unit for **Medicaid only** institutionalized recipients upon:

- Discharge from the nursing home to the hospital
- Discharge from the nursing home to the community
- Expiration in the nursing home
- Readmission to the nursing home from the hospital

**NOTE:**

Medicaid pays the hospice 95% of the nursing home rate applicable for that year for the room and board that would have been paid to the nursing facility for that individual under the State Plan. Providers should submit to Medicaid for reimbursement 95% of the Medicaid per diem rate for the nursing home in which the recipient resides.

**Medicare/Medicaid Eligibility**

The Hospice Election and Physicians Certification Form 165 must be completed for all recipients who are Medicaid eligible. However, for dually eligible recipients who have Medicare Part A, Medicare will pay the daily hospice rate for the appropriate level of care – routine, continuous, inpatient respite, or general inpatient.

If the dually eligible hospice recipient with Part A Medicare resides in a nursing facility, Medicare pays the daily hospice rate as usual. Providers should submit to Medicaid for reimbursement 95% of the Medicaid per diem rate for the nursing home in which the recipient resides. The number of days of Medicare coverage must equal the number of days requested for nursing facility room and board. Any applicable resource liability amount and/or third party liability amount is deducted from the payment made to the Hospice provider for the facility services.

The Qualified Medicare Beneficiary (QMB) recipient who has **QMB-only** is not eligible for any Medicaid benefits, i.e., home health, hospice, medications, etc. A recipient who has **QMB+** does have full Medicaid benefits and would be eligible for home health, hospice, and medications.

Coinsurance amounts for drugs and biologicals or respite care may be billed to Medicaid as crossover claims for dually eligible recipients for whom Medicare is the primary payer.

Drugs and biologicals furnished by the hospital while the recipient is not an inpatient may be billed at 5 percent of the cost of the drug or biologicals, not to exceed $5.00 per prescription.

**Medicaid Waiver Eligibility**

A Medicaid-only recipient cannot receive hospice services and waiver services simultaneously; however, a Medicare/Medicaid-eligible recipient may receive the hospice benefit and waiver service if Medicare is the payer for the hospice service. The hospice provider must inform Medicaid recipients receiving Medicaid Waiver Services that they will lose Medicaid Waiver Services when they elect to receive hospice benefits and notify the Waiver Provider of the election of the hospice benefit.

**Audits**

The provider of hospice care may be asked to furnish the Medicaid Hospice Care Program with information regarding claims submitted to Medicaid. The provider of hospice care must permit access to all Medicaid records and facilities for the purpose of claims audit, program monitoring, and utilization review by duly authorized representatives of federal and state agencies.

The provider of hospice care must maintain complete and accurate medical and fiscal records that fully disclose the extent of the services and billings. The provider retains these records for the period of time required by state and federal laws.

**Inpatient Respite Care**

Medicaid pays coinsurance claims for inpatient respite care, drugs, and biologicals for dually eligible recipients. Medicaid pays 5 percent of the Medicare payment for a day of respite care. This payment will not exceed the inpatient hospital deductible applicable for the year in which the hospice co-insurance period began. Medicaid will not pay for more than five consecutive days.

Medicaid pays 5 percent of the cost of each palliative drug and biological prescription furnished by the hospice while the individual is not an inpatient. The cost may not exceed $5.00 for each prescription.

**NOTE:**

When filing coinsurance claims for inpatient respite care or for drugs and biologicals, the provider must complete the UB-92 claim form. See Section 5.6.2, Institutional Medicaid/Medicare Related Claim Filing Instructions, for instructions on completing the crossover claim form.

## 18.3 Medicaid Approval for Hospice Care

Providers must adhere to all state and federal specific timeframes and documentation requirements under the Medicaid Hospice Program.

**Effective February 1, 2006, all hospice providers are subject to a 100% review of medical records containing documentation of admission; including hospice stays of six months or more. Hospice providers will no longer have the ability to submit dates of service to the LTC file for hospice admission or recertification.**

**Policies and Procedures for Hospice Admission and Recertification**

- Applicants to Medicaid approved hospice providers must be certified, by their attending physician or hospice medical director, to have a terminal illness with a life expectancy of six months or less. The certification for terminal illness is substantiated by specific findings and other medical documentation including, but not limited to, medical records, labs, x-rays, pathology reports, etc.
- The hospice provider will be required to comply with all state and federal rules related to an individual's election of the hospice benefit.
- The hospice provider must establish a permanent medical record for each patient which documents eligibility for the Medicaid Hospice benefit based upon the medical criteria found in the Alabama Medicaid Agency Administrative Code Rule 560-X-51-.04. Pediatric cases and other diagnoses not found in the Administrative Code will be reviewed on a case by case basis.
- All hospice providers certifying patient initial admission, recertification or hospice stays for six months or more must submit medical documentation to the LTC Admissions Records Unit for review. When approved the LTC Admissions/Records Unit will submit the dates of service to the LTC file.
- When submitting records the Hospice Program cover sheet must accompany the medical record. Mail the information to:

  **Alabama Medicaid Agency**

  **LTC Admissions/Records**

  **P.O. Box 5624**

  **Montgomery, AL 36103-5624**

- The LTC Admissions/Records Nurse Reviewer will review the documentation to ensure the appropriateness of admission based on Medicaid's medical criteria for admission as defined in the Alabama Medicaid Agency Administrative Code Rule No. 560-X-51-.04.
- If there are no established criteria for the admitting hospice diagnosis, the Nurse Reviewer will perform a preliminary review of the documentation for terminality and the normal progression of the terminal disease. The Medicaid Agency's Medical Director will make the final determination of approval or denial of the admission and continued stay in the Hospice Program for those diagnoses which have no established medical criteria.

- When there is both medical and financial approval, the application dates will be added to the LTC file by staff in LTC Admissions/Records. The application should not be forwarded for medical review until financial eligibility has been established.
- If the hospice provider submits documentation which appears to be incomplete (i.e. Medicaid Hospice Election Form 165 is missing, etc.) the provider will receive a letter requesting the additional information. If the additional information is not received within 10 days the application will be denied.
- No hospice segment will be approved by LTC Admissions/Records staff for greater than six months. If a recipient remains on hospice beyond six months, the provider must submit documentation which supports continued appropriateness for hospice including documentation of the continued progression of the disease. This information should be forwarded to the LTC Admissions/Records Unit for review two weeks prior to the end of the six month certification period or the case will automatically close. If the documentation demonstrates progression of the terminal illness, then an additional six month certification period will be established and added to the LTC file by the Admissions/Records staff.
- An acceptance will be faxed to the provider within 48 hours of completion of the review. This acceptance will notify the provider of the dates added to the file and may be used for billing of hospice claims.
- Denial letters will be mailed to the provider within two working days.
- All revocations and or discharges should be faxed to the LTC Admissions/Records Unit using the Hospice Recipient Status Change Form.

## 18.4 Cost Sharing (Copayment)

Copayment amount does not apply to services provided by a Hospice provider.

## 18.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers are encouraged to bill Medicaid claims electronically.

➢ Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

Hospice providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

**NOTE:**

When filing a claim on paper, a hard copy UB-92 claim form is required. Medicare-related claims should be filed using the Institutional Medicaid/Medicare Related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

### *18.5.1 Time Limit for Filing Claims*

Medicaid requires all claims for Hospice providers to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

### *18.5.2 Diagnosis Codes*

The International *Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

**NOTE:**

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

### *18.5.3 Procedure Codes, Revenue Codes and Modifiers*

Hospice providers are required to use HCPCS procedure codes for each service rendered. Failure to identify each service with a procedure code will result in denial of the service. The (837) Institutional electronic claim and the paper claim have been modified to accept up to four Procedure Code Modifiers.

Payment of hospice services is limited to the following codes:

| *Revenue Code* | *Procedure Code* | *Description* |
|---|---|---|
| 651 | T2042 | Routine home care, per day |
| 652 | T2042-SC | Continuous home care, per day |
| 655 | T2044 | Inpatient respite care, per day |
| 656 | T2045 | General inpatient care, per day |
| 659 | T2046 | Nursing facility room and board, Routine care, per day |
| | T2046-SC | Nursing facility room and board, Continuous care, per day |
| | T2046-SE | Nursing facility room and board, per dually eligible recipient, per day |

### *18.5.4 Place of Service Codes*

Place of service codes do not apply when filing the UB-92 claim form.

### *18.5.5 Required Attachments*

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to claims with third party denials.

| **NOTE:** |
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| When an attachment is required, a hard copy UB-92 claim form must be submitted. |

Refer to Section 5.7, Required Attachments, for more information on attachments.

## 18.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

| Resource | Where to Find It |
| --- | --- |
| UB-92 Claim Filing Instructions | Section 5.3 |
| Institutional Medicaid/Medicare-related Claim Filing Instructions | Section 5.6.2 |
| Electronic Media Claims (EMC) Submission Guidelines | Appendix B |
| AVRS Quick Reference Guide | Appendix L |
| Alabama Medicaid Contact Information | Appendix N |